

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445278	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2012
NAME OF PROVIDER OR SUPPLIER BROOKWOOD NURSING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain the sprinkler system components.</p> <p>The findings include:</p> <p>Observation on September 24, 2012 at 2:10 p.m. revealed that lent and paint was on sprinkler heads in the following locations:</p> <ol style="list-style-type: none"> Residents rooms (lent build up) Janitor's closet in kitchen (painted sprinkler head) Dining room by vending machine (painted sprinkler head) <p>These findings were verified by the Maintenance Director and acknowledged by the administrator during the exit conference on September 24, 2012.</p>	K 062	<p>K 062</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ol style="list-style-type: none"> Maintenance department has cleaned the lent and paint off the sprinkler heads in: the sited rooms, janitor's closet in the kitchen, and in the dining room by the vending machine on 10/01/12. <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <ol style="list-style-type: none"> Maintenance department will closely check sprinkler heads in the area following any contractors work and/or repairs for any paint or debris that may have collected on any sprinkler heads in the area of said work and/or repair. <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur?</p>	
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>	K 064		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Administrator POB 3 10/18/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain the sprinkler system components.</p> <p>The findings include:</p> <p>Observation on September 24, 2012 at 2:10 p.m. revealed that lent and paint was on sprinkler heads in the following locations:</p> <ol style="list-style-type: none"> 1. Residents rooms (lent build up) 2. Janitor's closet in kitchen (painted sprinkler head) 3. Dining room by vending machine (painted sprinkler head) <p>These findings were verified by the Maintenance Director and acknowledged by the administrator during the exit conference on September 24, 2012.</p>	K 062	<p>1. Maintenance department will systematically check all sprinkler heads in the building by adding the sprinkler heads to the monthly room check list, beginning 10/01/12.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place.</p> <p>1. Maintenance department will provide synopsis of monthly room check list in the QA meetings, beginning in October.</p>	10/17/12	
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>	K 064	<p>K 064</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>1. Maintenance department had the kitchen's fire extinguisher</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 064	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to maintain kitchen fire extinguisher. The findings include: Observation and record review on September 24, 2012 at 2:05 p.m. revealed that the kitchen k fire extinguisher did not have its hydrostatic test performed. The finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on September 24, 2012.	K 064	changed out for one with the hydrostatic test performed and documented on 9/26/12. How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	1. Maintenance department will review any fire extinguishers changed out to make sure all documentation is current. 2. Should any fire extinguishers that are changed out be found not to have the proper documentation in place, then Maintenance department will call and request the documentation or a replacement unit and notify the Administrator immediately. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur? 1. Maintenance will keep a log of all fire extinguishers in the building. Said log will include the last dates of any tests		

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K 064	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to maintain kitchen fire extinguisher. The findings include: Observation and record review on September 24, 2012 at 2:05 p.m. revealed that the kitchen k fire extinguisher did not have its hydrostatic test performed. The finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on September 24, 2012.	K 064	performed. How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place. 1. Maintenance department will review these logs in QA, beginning in October.	9/26/12	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	K 066 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. Self closing metal containers were obtained and put into place, with Nursing, Maintenance, Housekeeping departments scheduled to empty these containers following each smoke break beginning 9/26/12. How will you identify other residents having the potential to be affected by the same alleged practice(s) and what		

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K 066	Continued From page 2 permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to follow smoking regulations. The findings include: Observation on September 24, 2012 at 3:00 p.m. revealed the facility did not provide metal containers with self-closing cover devices into which ashtrays can be emptied into for smoking areas. The finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on September 24, 2012.	K 066	corrective action will be taken? 1 Current self contained smoking stand was fitted with a lock by the DON and ADON, so that the residents would be unable to access cigarette butts on 9/27/12. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur? 1. Another self contained metal smoker's stand that can be locked was ordered. Stand and lock put in place 10/3/12.	10/3/12	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to smoke and fire dampers. The findings include:	K 067	How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place. 1. Maintenance will empty these self contained metal smoker's stands twice weekly.		

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:216H21

Facility ID: TN6101

If continuation sheet Page 3 of 4

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K 067	Continued From page 3 Record review and interview on September 24, 2012 at 11:30 a.m. confirmed that the facility failed to perform the 4-year smoke and fire damper maintenance. The finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on September 24, 2012.	K 067	the same alleged practice(s) and what corrective action will be taken? 1. Maintenance called Simplex for information on the 4 year smoke and fire damper maintenance on 10/9/12, 10/15/12, 10/17/12, and 10/18/12 without results. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur? 1. Todd Grant from Grants Heating and Air will come to the facility and perform the 4 year smoke and fire damper maintenance. How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place. 1. Maintenance department or Administrator will schedule this smoke and fire damper maintenance at least every 4 years.	10/18/12	